UTAH STATE DEVELOPMENTAL CENTER
REQUEST FOR OUTPATIENT DENTAL SERVICES

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TO AVOID DELAY IN REQUEST, PLEASE RESPOND COMPLETELY TO ALL AREAS
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SERVICE REQUEST FOR:

Name:	Date of Birth:
Social Security #:	Telephone:
Address:	
Is the above individual currently receiving services from the Division of Services for People with Disabilities? Yes ☐ No ☐	
Type of service:	

PERSON REQUESTING SERVICES IF OTHER THAN ABOVE:

Name:	Title:
Address:	Telephone:
Relationship to patient (DSPD regional staff, ICF/MR, QMRP, other):	
When is the best time to contact you?	
Additional contact (Support Coordinator, QMRP, etc.):	
Telephone:	
Legal Guardian:	
Address:	Telephone:

INSURANCE INFORMATION:

Name of Insurance Company(ies):	
ID#:	
Policy Holder:	
Medicaid #:	Medicare #:
Who will pay for services not covered by insurance?	
Billing Address:	Telephone:

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MEDICAL HISTORY INFORMATION:

Primary Physician:	Telephone:
Primary Dentist:	Telephone:
What type of anesthesia has been used for previous dental appointments (nitrous oxide, general anesthesia, local anesthesia, etc.)?	
Is the above individual currently in dental pain? Yes ☐ No ☐	
Please list chief dental complaint:	
When was your last dental visit (include date, provider and provider phone number):	

LIST PRIVATE PROVIDERS PREVIOUSLY CONTACTED FOR REQUESTED SERVICES:

Name, Address and Telephone	Reason for Denied Services

*AUTHORIZED SIGNATURES REQUIRED PRIOR TO SERVICE DELIVERY *

∗1) Region Director:

OR

Nursing Home Administrator:
∗2) Developmental Center Medical Services Director:
∗3) Developmental Center Administrator:
*4) Developmental Center Dentist:
5) Business Office:

MEDICAL HISTORY FORM

MEDICAL AND DENTAL RECORDS MUST ACCOMPANY THIS FORM

For your safety please answer all questions carefully and honestly

	Yes	No
1. Have you ever been a patient at USDC?		
2. Are you taking or have you ever taken blood thinners, Coumadin, prednisone, heart pills, steroids, nerve pills, blood pressure pills, Fen Phen (diet pills) or Insulin? (circle which)		
3. Do you use herbal or food supplements? If yes, please list		
4. List any medications you are now taking or have taken in the past four months (Females – Are you taking a birth control pill? There is a higher incidence of "Dry Socket" with that medication. Also, if antibiotics are prescribed, the effectiveness of a birth control pill may be reduced and a pregnancy may occur) :		
5. Are you allergic to, or have had an unfavorable reaction to any medication?		
6. Do you itch, wheeze or get a rash from latex or a rubber product?		
7. Have you had an unfavorable reaction to local (numbing) or general (asleep) anesthetics?		
8. Do you use recreational drugs – i.e. : L.S.D., "Speed", "Downers", Mescaline, Cocaine, others?		
9. Have you ever been hospitalized or operated on? List year and reason:		
10. Have you had an unfavorable reaction from previous dental treatment?		
11. Do you get infections, sores, boils, sore throat or respiratory problems easily?		
12. Have you ever had Radiation Therapy for tumors?		
13. Have you or any family member had problems breathing following an anesthetic?		
14. Have you had recent weight changes or history of fever or chills and excessive sweating?		
15. What is your current Height? Weight?		
16. Do you get frequent headaches?		
17. Do you wear glasses, contact lenses, see double, or have glaucoma? (circle which)		
18. Do you have/had hearing difficulties, ringing in your ears, dizziness, earaches, drainage from ears, sinusitis, frequent nose bleeds, difficulty breathing through your nose? (circle which)		
19. Do you have/had breathing problems such as asthma, wheezing, T.B., chronic cough, coughed up blood, coughing spells, excessive sweating, emphysema? (circle which)		
20. Do you smoke? Packs per day? Use Alcohol?		
21. Do you have/had heart trouble, angina, chest pain, shortness of breath while laying flat or while climbing stairs; irregular pulse, palpitation, high blood pressure, heart murmur, rheumatic fever, dizziness, or fainting when getting up suddenly, ankle swelling, stroke? (circle one)		
22. Do you have/had stomach or liver problems, ulcer, vomited blood, colitis, yellow jaundice, hepatitis, frequent constipation? (circle which)		
23. Do you have/had kidney problems, frequent urination, frequent night time urination, nephritis, difficulty urinating, burning, blood in urine? (circle which)		
24. (Women) – Are you pregnant? Month?		
Number of past pregnancies: Are you nursing at present?		
25. Do you have/had thyroid trouble, fast heart rate, hot or cold intolerance? (circle which)		
26. Do you have diabetes, hypo-glycemia, chronic thirst? (circle which)		
27. Do you have/had rheumatoid arthritis, broken bones, muscular dystrophy, polio (circle which)		
28. Does/has your jaw popped, clicked, cracked or locked open or shut (circle which)		
29. Have you been diagnosed with HIV, AIDS or ARC (auto-immune disorders)?		
30. Do you have/had anemia, bleeding problems, bruise easily, hemophilia? (circle which)		
31. Do you have/had fainting spells, convulsions, epilepsy, use Dilantin, subject to nervous disorder?		
32. Do you have Anorexia or Bulimia?		

Please check the boxes below:

- ❑ I have reviewed the above, and it is current and accurate.
- ❑ I have attached complete medical and dental historical records

Signature _____ Date_____

Patient, Parent, Guardian (circle)